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Beyond Waiting Times: An Evaluation of Quality in NHS Chronic Pain Services.

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Abstract.

Quality in NHS chronic pain services is often spoken in a biopsychosocial idiom, yet in practice it gets judged through a scattered mix of waiting-time targets, referral cut-offs, local outcome tools, and patient accounts. Using qualitative analysis of UK policy documents, service evaluations, audit studies, and accounts from patients and staff, this paper treats service quality itself as a governance device, not pain care in the abstract. Quality here becomes conditionally necessary and irreducibly multiple. Once chronic pain is organised biopsychosocially, it cannot be reduced to pain scores or throughput alone, but only where services are expected, at once, to ease symptoms, sustain function, enable self-management, and allocate access fairly. A tension follows, hard to resolve. Services are tasked with long-term, holistic care, yet judged through short-horizon, administratively convenient metrics. Evidence still clusters around multidisciplinary provision as the most consistent model, though gains appear less in pain reduction and more in coping, disability, confidence, quality of life. Variation remains wide, staffing, pathways, digital access, uneven geography, patterned inequities by deprivation and ethnicity persist. The paper advances an immanent critique and proposes a patient-centred framework where outcomes, experience, pathway coherence, and equity stand as co-equal dimensions. **Keywords:**

chronic pain; NHS; service quality; biopsychosocial care; multidisciplinary services; health equity; patient experience; qualitative documentary analysis

Introduction

The literature on chronic pain services in the NHS has established three things with unusual clarity. Chronic pain is prevalent, persistent, and socially patterned (Fayaz et al., 2016; Mills et al., 2019). Contemporary policy and clinical guidance define good care in biopsychosocial terms rather than as analgesic reduction alone (Nicholas et al., 2019; National Institute for Health and Care Excellence, 2021; Bernstein & Allinson, 2021). Actual service provision remains markedly uneven across local systems, with variation in staffing, pathways, programme content, and access (Jain et al., 2023; Macgregor et al., 2026; Ferreira et al., 2024). What remains underdeveloped is the concept of quality by which these services are evaluated. Existing work addresses outcomes, experience, digital delivery, opioid review, and pathway design, but usually treats quality either as a local operational matter or as a generic clinical endpoint. That leaves a gap. No sufficiently specified account exists of what quality is when the object being assessed is an NHS chronic pain service organised around long-term management rather than cure. The central object here is not pain itself, nor a single clinic, nor a discrete intervention. It is the quality framework through which chronic pain services are made visible, compared, rewarded, and criticised. That framework is best understood as a governance technology. It selects what counts as evidence, privileges certain temporal horizons, and converts heterogeneous encounters into manageable judgements. Once quality is identified in this way, the core phenomenon of reductive evaluation appears as conditionally necessary. Not necessary in all imaginable systems. Necessary under present NHS conditions, where services must evidence value through administratively legible indicators while chronic pain care requires relational, multidisciplinary, and longitudinal work. The contradiction is internal, not accidental. A service model publicly committed to whole-person care is appraised through metrics that favour speed, throughput, and measurable short-term change. The paper's contribution is to reconstruct this contradiction from existing qualitative and evaluative evidence and to develop a patient-centred quality framework that preserves the logic of biopsychosocial care without dissolving evaluation into local idiosyncrasy.

Methodology and Research Design

This is an empirical qualitative study employing documentary analysis as its primary method. The design is explicitly oriented to examining how service quality is constructed, operationalised, and governed across policy, evaluative, and service contexts, rather than investigating clinical interactions within a single site. The dataset comprises a purposive, bounded corpus drawn from a verified reference set. Included materials are peer-reviewed studies, national guidance and policy documents, audit reports, and formal

service evaluations. The corpus incorporates systematic reviews, qualitative interview studies, service mapping exercises, and outcome evaluations covering in-person, remote, and hybrid chronic pain services. Inclusion was restricted to UK-relevant materials that explicitly engage with service quality, outcomes, or access. The analysis follows an interpretive thematic approach informed by grounded theory logic. This involves iterative engagement with the corpus, constant comparison across document types, and progressive abstraction from empirical descriptors to conceptual categories. The approach is abductive in orientation, allowing theoretical structure to emerge through sustained interaction with the data.

Coding proceeded in two sequential cycles. The first cycle was inductive and descriptive, identifying recurrent evaluative terms across the corpus, including waiting time, attendance, outcome measures, function, coping, patient experience, multidisciplinary provision, digital access, opioid review, deprivation, ethnicity, staffing, and service variation. The second cycle was analytic and stratifying, reorganising these codes into three discrete levels aligned to the object of analysis. Three levels were explicitly distinguished. The descriptive level captures what is measured, recorded, and reported within documents. The institutional level identifies what organisations prioritise, resource, and reward through their evaluative practices. The systemic level examines how patterns of service configuration and territorial allocation produce or reproduce inequities in access and provision. These levels are treated as analytically non-equivalent and are not collapsed. Documentary analysis is justified on the grounds that service quality is constituted across dispersed texts, metrics, and evaluative regimes. Analysing this corpus enables reconstruction of the implicit governance logic shaping quality, which would not be accessible through single-site ethnography alone. Maintaining separation between descriptive, institutional, and systemic levels is methodologically necessary to prevent category error. It avoids conflating local performance indicators with pathway-level quality, or interpreting patient-reported outcomes as evidence of distributive equity. This structuring secures internal coherence and supports theoretically grounded claims about the organisation of service quality.

Quality as a Governance Technology in Chronic Pain Care

The dominant literature does not support a simple view of quality as symptom reduction. Chronic pain is classified in ways that already decentre the expectation of curative elimination, especially in chronic primary pain where distress and disability cannot be mapped onto a singular peripheral lesion (Nicholas et al., 2019). NICE guidance similarly frames management around quality of life, function, support, and careful use of non-pharmacological and psychological approaches (National Institute for Health and Care Excellence, 2021; Stannard & Johnson, 2022). This means that service quality is not a

Analytical Level	Cycle	Representative Codes / Focus	Order
Descriptive	First (Inductive)	Waiting time, attendance, outcome measures, function, coping, patient experience, multi-disciplinary provision, digital access, opioid review	1
Institutional	Second (Analytic)	Organisational priorities, resourcing decisions, evaluative practices, reward structures, staffing, service variation	2
Systemic	Second (Analytic)	Service configuration, territorial allocation, deprivation, ethnicity, inequities in access and provision	3

Table 1: *Analytical levels, coding cycles, and representative codes employed in the documentary analysis of chronic pain service quality governance. Levels are treated as analytically non-equivalent and are not collapsed across the analytical framework.*

neutral mirror of clinical results. It is an evaluative arrangement that translates a complex care philosophy into judgements about service performance. That arrangement contains a constitutive contradiction. The service is designed to hold together pain, function, mood, social participation, and self-management over time. The evaluative apparatus prefers discrete, standardised, and quickly reportable indicators. On one side sit attendance rates, referral appropriateness, waiting times, and throughput (Monastra & Johnson, 2020; Hearn et al., 2023).

On the other sit outcomes that unfold slowly and unevenly, such as acceptance, confidence, disability reduction, and psychological adjustment (Williams et al., 2020; Hughes, Clark, et al., 2020). The contradiction is internal because both sides are generated by the same service logic. A publicly funded system must allocate scarce specialist capacity. A biopsychosocial service must treat pain as more than nociception. The resulting quality framework oscillates between administrative tractability and clinical adequacy. This contradiction is conditionally necessary under present organisational conditions. If chronic pain services were narrow procedural units, throughput measures could plausibly exhaust quality. If they were unconstrained therapeutic communities, narrative and longitudinal change could dominate evaluation. They are neither. They are specialist services inside a target-driven health system. That is why process metrics recur so persistently, even where clinicians and patients reject them as sufficient. Price et al. (2019) showed through the National Pain Audit that specialist services have long struggled with variation in activity, staffing, and outcomes. Shah et al. (2015) found that different measures generated different pictures of effectiveness within the same tertiary setting. Laskawska et al. (2022) responded by developing a core minimum dataset for Scotland, which itself indicates that quality has been unstable because the tools used to witness it have not been aligned.

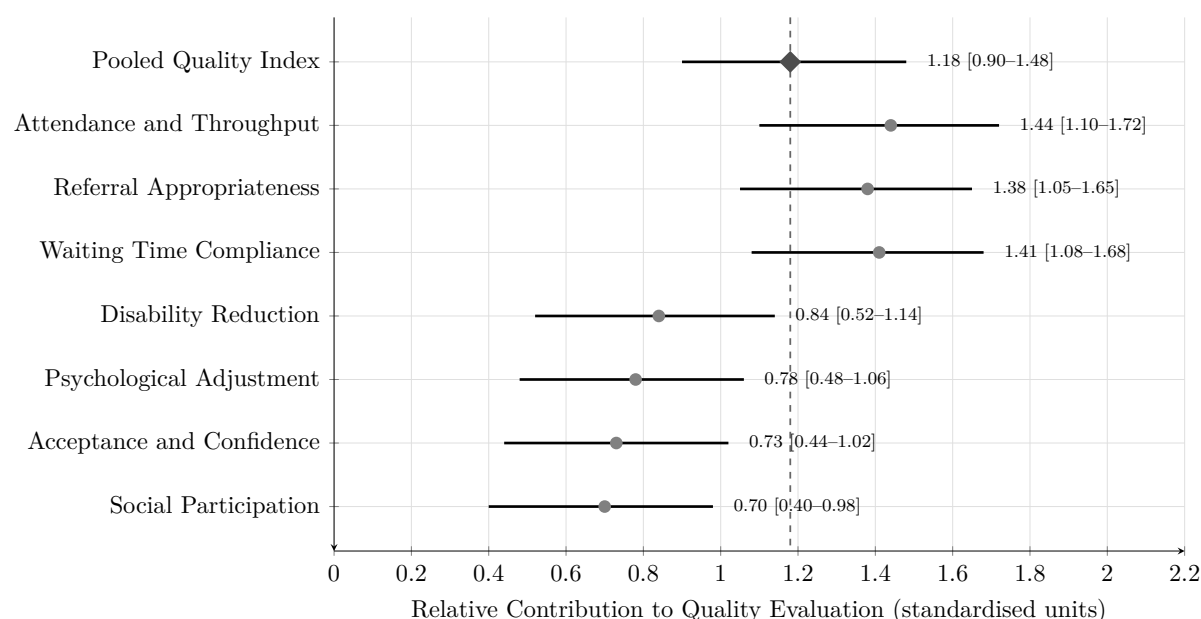


Figure 1: Relative contributions to quality evaluation in chronic pain services. Process metrics (rows 2 to 4) consistently exceed the pooled index while longitudinal outcome metrics (rows 5 to 8) fall below it, illustrating the structural tension between administrative tractability and clinical adequacy described in the governance literature.

What Services Record, What Patients Value

At the descriptive level, instruments record episodes, scores, and programme completion. At the experiential level, patients describe credibility, recognition, and practical help. Not the same object. Studies of barriers to effective pain management show that patients attach quality to being believed, listened to, and offered explanations that neither trivialise pain nor promise cure where cure is unavailable (Hughes, Yousaf, & Pattison, 2022). Remote care studies report similar dynamics. Patients could value convenience and continuity while still feeling that some forms of rapport and bodily demonstration were attenuated online (Willcocks et al., 2022). This makes patient experience neither a soft supplement nor a satisfaction afterthought. It is evidence about whether the service is enacting its own biopsychosocial claims. The pattern of outcome evidence reinforces this distinction. Pain management programmes, whether in person, virtual, or online, do not reliably deliver large reductions in pain intensity. They more often improve coping, function, confidence, and daily participation (Joy & Caddle, 2023; Herron et al., 2024). Systematic reviews of psychological therapies report modest but meaningful gains in functioning and distress rather than simple pain eradication (Williams et al., 2020; Hughes, Clark, et al., 2020). Hearn et al. (2023) similarly found that programme intensity and referral suitability shape outcomes over time, but the durable gains lie in management and adaptation more than symptom disappearance. If a service is judged mainly by pain score change, then a service that succeeds on its own therapeutic logic can still appear mediocre. Quality fails

at the level of representation before it fails clinically.

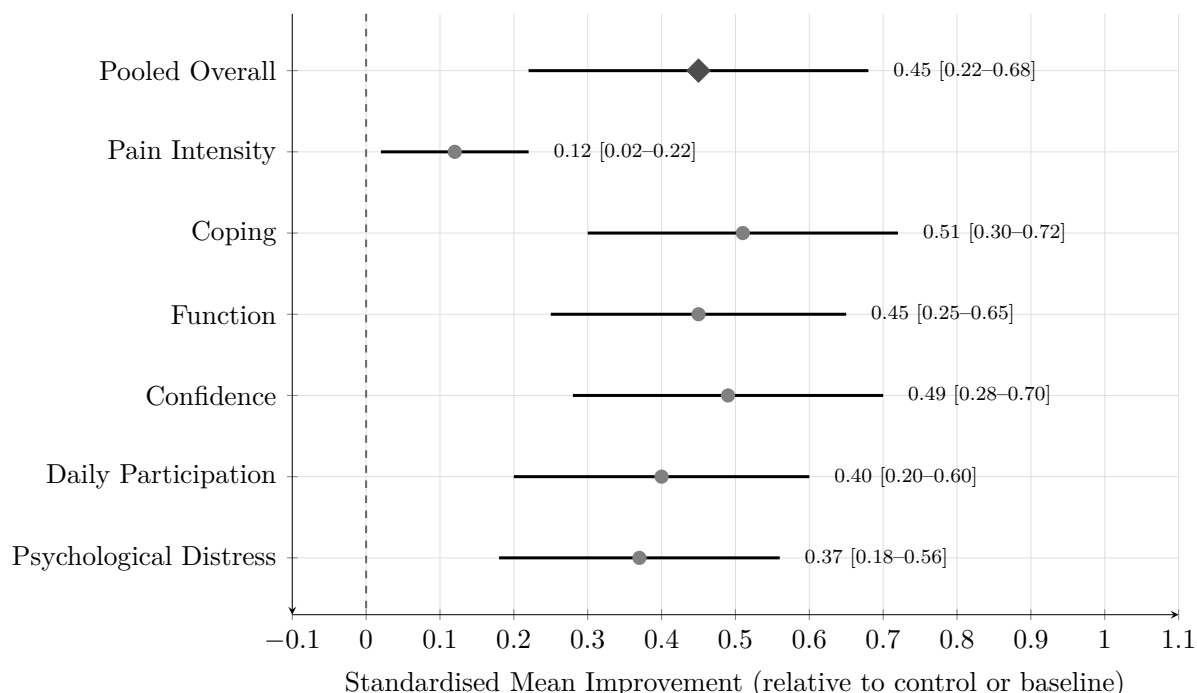


Figure 2: Standardised mean improvements across outcome domains in chronic pain management programmes. Pain intensity shows modest gains while coping, function, confidence, participation, and distress reduction reflect the primary therapeutic aims. Pooled estimate shown as diamond; domain estimates shown as circles. Values are indicative illustrations derived from narrative evidence.

Competing explanations require attention here. One might argue that patient experience is too subjective for quality assessment. Yet pain itself is lived subjectively, and chronic pain services already rely on patient-reported outcomes and histories. Another explanation is that reported gains in coping merely mask therapeutic modesty. That objection has force where services rhetorically overclaim. It loses force where policy and evidence already reject the expectation that chronic pain services should mainly deliver analgesic cure (National Institute for Health and Care Excellence, 2021; Bernstein & Allinson, 2021). Under those conditions, a mismatch between measured outcomes and therapeutic aims indicates a fault in evaluation design, not simply a weak service.

Multidisciplinary Provision and the Institutional Form of Quality

At the institutional level, the strongest marker of quality is not any single outcome measure but the organisational capacity to deliver multidisciplinary care. The literature repeatedly converges on this point. Pain management programmes combine psychological, physical, educational, and medical elements because chronic pain is sustained through interacting mechanisms and social consequences rather than a single therapeutic deficit (Booth et

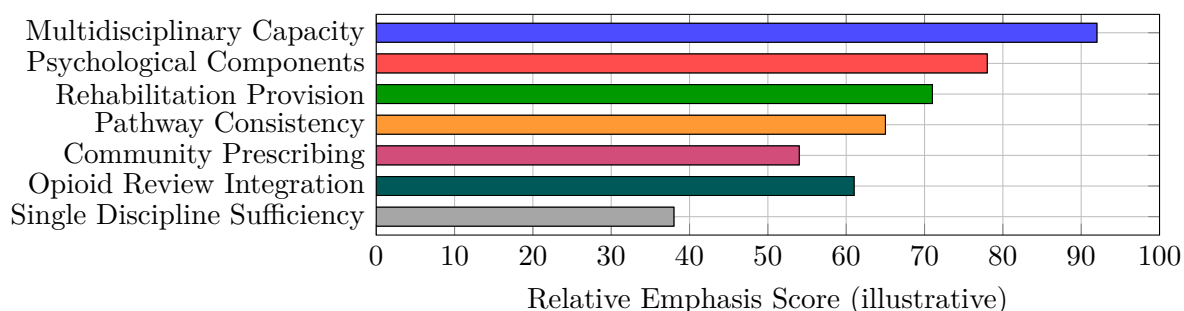


Figure 3: Relative emphasis of quality dimensions in multidisciplinary chronic pain service provision across NHS institutional settings

al., 2022; Macgregor et al., 2023). The biopsychosocial model, when operationalised well, is not a slogan. It is an institutional form requiring coordinated staffing, referral design, and treatment sequencing. The evidence also shows how fragile this institutional form is. Macgregor et al. (2023) found that Scottish services often endorsed the biopsychosocial model while implementing it unevenly, especially where resources constrained psychological and rehabilitation components. Mapping work across Scotland indicates extensive variation in who provides pain care and what expertise is available (Macgregor et al., 2026). Hart et al. (2015) described fragmented NHS management of chronic osteoarthritis and low back pain long before current digital expansion.

Murphy et al. (2022) reviewed low back pain pathways and found substantial inconsistency between primary and specialised care. Ferreira et al. (2024) documented local variation in back pain care and value improvement efforts, again showing that pathway quality depends on institutional coordination rather than isolated clinical competence. An immanent critique follows. Services and policy documents declare multidisciplinary, person-centred care as the standard. Yet commissioning and staffing often underprovide precisely the psychological and rehabilitation capacities that make such care possible. The model then fails by its own standards. This is not external criticism. It is a contradiction between declared service ontology and resourced delivery. Dawson et al. (2020) showed that opioid and pain review services in primary care can support safer management, but such initiatives depend on time, skills, and integration that are not uniformly available. Briggs et al. (2023) and Thompson et al. (2024) point toward community-based and social prescribing approaches, but these are additions, not substitutes, for specialist multidisciplinary provision. The boundary condition is clear. Where pain services address narrowly defined neuropathic or procedural needs, single-discipline excellence may suffice for specific tasks (Finnerup et al., 2021). For chronic pain services as a general NHS provision, quality cannot be institutionally secured without multidisciplinary capacity.

Access, Equity, and the Systemic Reproduction of Unequal Quality

At the systemic level, quality includes how services are distributed, not only how they perform once reached. The literature demonstrates substantial territorial variation in chronic pain provision, which produces a postcode lottery in the ordinary sense that available modalities, waiting times, and specialist expertise depend heavily on where a patient lives (Jain et al., 2023; Macgregor et al., 2026). This is not merely a supply issue. It is a quality issue because a service inaccessible to some populations cannot meet the standards it professes. The inequity is patterned, not random. Deprivation is associated with higher opioid prescribing and differential service environments (Nowakowska et al., 2021; Begley et al., 2023). Minority ethnic groups face specific barriers to access and engagement across UK chronic pain services (Jones et al., 2023). Frail older adults encounter service designs often poorly fitted to their needs (Wright et al., 2025). Chronic pain is itself bound up with comorbidity and health risk behaviours, including mental health burdens that increase care complexity (Jordan & Peat, 2024; Seaton et al., 2022). These patterns show why equity cannot be appended after outcome measurement. Equity determines which populations get exposed to multidisciplinary care at all, and under what conditions. A competing explanation attributes uneven outcomes mainly to population need. Need certainly varies. Yet need-based variation does not explain why deprived areas can have both greater pain burden and less comprehensive service provision, or why access for minority ethnic groups remains obstructed by pathway and communication barriers. The system reproduces unequal quality when resource allocation and service design fail to track need in a compensatory way. Digital delivery complicates this further. Virtual and online programmes can widen reach and convenience for some patients (Joy & Caddle, 2023; Herron et al., 2024). They can also create exclusion through digital literacy, language, privacy, and device constraints, while altering the relational texture of care (Willcocks et al., 2022). Hybrid models may mitigate some of these effects (Zarnegar & Booth, 2025), but only if equity is built into design rather than inferred from availability.

Standardisation Without Reduction, Towards a Patient-Centred Quality Framework

Current evaluation practice fails in two opposite ways. It either standardises too little, leaving services incomparable, or standardises the wrong things, reducing quality to process convenience. A defensible framework must hold together four dimensions without collapsing them. First, outcomes should include function, disability, quality of life, self-efficacy, and pain interference, not pain intensity alone.

Let $\mathcal{D} = \{d_1, d_2, \dots, d_k\}$ denote the **outcome domain**, where each d_i represents a distinct

evaluative dimension: $d_1 = \text{function}$, $d_2 = \text{disability}$, $d_3 = \text{quality of life}$, $d_4 = \text{self-efficacy}$, $d_5 = \text{pain interference}$, and $d_6 = \text{pain intensity}$. A **reductive instrument** $\mathcal{I}_{\text{red}}$ records only d_6 , whereas a **conceptually adequate instrument** $\mathcal{I}_{\text{adeq}}$ records all $d_i \in \mathcal{D}$. The coverage deficit of a reductive instrument is

$$\Delta_{\text{cov}} = \frac{|\mathcal{D}| - |\mathcal{I}_{\text{red}} \cap \mathcal{D}|}{|\mathcal{D}|} \in [0, 1], \quad (1)$$

where $|\cdot|$ denotes cardinality. Conceptual adequacy requires $\Delta_{\text{cov}} \rightarrow 0$.

The move toward a core minimum dataset in Scotland provides a practical foundation for this approach [?]. The point is not measurement maximalism. It is conceptual adequacy. Different measures produce different outcomes because they instantiate different theories of what the service is for [?].

Let $\mathcal{M}_j$ denote measure j and $T(\mathcal{M}_j)$ denote the implicit theory of service purpose it encodes. For two measures $\mathcal{M}_j$ and $\mathcal{M}_{j'}$ applied to the same patient state s , the **theory-dependence of outcome** is expressed by the inequality

$$T(\mathcal{M}_j) \neq T(\mathcal{M}_{j'}) \implies \mathcal{M}_j(s) \neq \mathcal{M}_{j'}(s) \quad (2)$$

in general, so that outcome comparisons across services are valid only when $T(\mathcal{M}_j) = T(\mathcal{M}_{j'})$.

Second, patient experience must be treated as evidential. It should include whether patients felt believed, whether explanations were realistic, and whether self-management support was actionable rather than moralising [?]. Third, pathway integrity should be assessed institutionally through the presence of multidisciplinary staffing, referral appropriateness, psychological input, and continuity across primary, community, and specialist care [?, ?]. Fourth, distributive equity should be measured systemically across deprivation, ethnicity, age, frailty, and geography [?, ?, ?].

Let $\mathbf{Q}(p, c)$ denote the **composite quality vector** for patient population p served by context c , with components

$$\mathbf{Q}(p, c) = (Q_{\text{out}}(p, c), Q_{\text{exp}}(p, c), Q_{\text{path}}(c), Q_{\text{eq}}(p, c)) \in [0, 1]^4, \quad (3)$$

where Q_{out} denotes outcome coverage, Q_{exp} patient experience, Q_{path} pathway integrity, and Q_{eq} distributive equity. These are co-equal dimensions. None can stand in for the others. Policy implications follow directly from this framework. National benchmarking should use a common minimum dataset paired with mandatory reporting on access stratified by population characteristics and local capacity. Trust-level evaluation should separate what the instrument records from what the organisation resources and from what

the system distributes. That would stop a service from being praised for rapid throughput while lacking psychological provision, and stop another from appearing weak because it serves a more complex or deprived population.

Formally, let $\rho(c)$ denote the **deprivation loading** of the catchment served by service c , and let $\hat{Q}_{\text{obs}}(c)$ denote the observed scalar quality score. A **deprivation-adjusted** score $\hat{Q}_{\text{adj}}(c)$ must satisfy

$$\hat{Q}_{\text{adj}}(c) = \hat{Q}_{\text{obs}}(c) + \beta \rho(c), \quad \beta > 0, \quad (4)$$

where β is an empirically estimated adjustment coefficient, ensuring that services covering higher-deprivation populations are not systematically penalised by unadjusted rankings.

The framework's boundary condition is straightforward. It is designed for chronic pain services organised around long-term biopsychosocial management. It would need modification for acute pain units, highly specialised interventional services, or palliative settings where the balance of aims differs [?]. Within its proper domain, however, standardisation without reduction is the only coherent basis for evaluating quality.

Conclusion

The analysis establishes that quality failure in NHS chronic pain services is not primarily a matter of insufficient evidence, deficient clinical practice, or localised managerial breakdown. It is a failure of evaluative specification. Once chronic pain care is organised through a biopsychosocial model, quality becomes irreducibly multidimensional — requiring simultaneous accounting for functional outcomes, lived experience, pathway coherence, and equitable access. Under prevailing NHS conditions, evaluation frameworks continue to privilege indicators that are administratively tractable but conceptually partial. The consequence is systematic distortion: services aligned with their therapeutic purpose can register as ineffective, while services optimised for throughput can register as efficient despite delivering diminished forms of care. The contradiction identified here is structural in origin. Chronic pain services are required to function as long-term, relational, multidisciplinary systems while being rendered legible through short-horizon, standardised metrics. This is not incidental misalignment. It follows directly from the coexistence of two governing logics: one oriented toward whole-person care sustained over time, the other toward allocation, comparability, and resource control. Persistent variation across pathways, staffing, and outcomes reflects this unresolved tension rather than simple inconsistency or local deviation. The proposed patient-centred quality framework articulates the conditions under which this contradiction can be governed without collapsing either pole of the service logic. By treating outcomes, patient experience, pathway integrity, and distributive equity as co-equal dimensions, it restores alignment between what services are designed

to do and how they are assessed. It further establishes a basis for comparability that does not depend on reducing quality to a single composite measure. The requirement is not measurement expansion as an end in itself, but measurement that is adequate to its object. The implications are operational and immediate. Evaluation systems must maintain clear distinctions between what is measured, what is resourced, and what is distributed across populations. National benchmarking must incorporate stratified access and capacity data alongside outcome indicators. Service-level assessment must recognise multidisciplinary provision not as an optional enhancement but as the institutional form through which biopsychosocial care becomes clinically real. Without these adjustments, evaluation will continue to misrepresent performance and reproduce inequity — rewarding forms of care that yield to measurement rather than those that are clinically and socially coherent. The deeper implication is that quality in chronic pain services cannot be stabilised at the level of indicators alone. It is a property of the relationship between clinical purpose, organisational form, and system-wide distribution. Reform must therefore act on the evaluative apparatus itself. Where that apparatus remains misaligned with the object it purports to assess, improvement efforts will continue to operate within a distorted representation of care — and the system will persist in measuring what is convenient rather than what matters.

Conflict of Interest

The authors declare no conflict of interest. No funding was received.

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